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To All Providers:

- In January 2006, the Indiana Health Coverage Programs (IHCP) is implementing a new Web registration and e-mail notification application that allows providers to subscribe to and receive notification via electronic mail when banner pages, bulletins, and newsletters are posted to the IHCP Web site. The notification will contain links to the types of publications to which a provider subscribes. This application will be located on the IHCP Web site at http://www.indianamedicaid.com.

  To receive notifications and links to banners, bulletins, and newsletters via e-mail, providers must register and subscribe to the specific types of publications. **Notifications and links to these publications will be distributed by e-mail**. Additional information about this new application is forthcoming.

- On January 1, 2006, the annual Healthcare Common Procedure Coding System (HCPCS) update and the 2005 October and July quarterly HCPCS updates, which include alphanumeric and Current Procedural Terminology (CPT®) codes, will be loaded in Indiana*AIM* with program coverage and pricing determinations. These codes will be available for claims processing on their respective effective dates. To view code coverage and pricing information for the 2006 Annual and the 2005 October and July Quarterly updates, please refer to the upcoming IHCP provider bulletin at www.indianamedicaid.com./ihcp/Publications/bulletin_results.asp

  The upcoming provider bulletin will be available in January 2006, and will outline the codes and their respective coverage determinations.

  In addition, the annual and quarterly updates include some new alphanumeric and CPT codes that require additional review by the IHCP. Providers will receive coverage and pricing determinations for these codes in a separate provider bulletin or banner page article, after the review is completed.

- Recently, EDS assigned the same IHCP provider bulletin number, *BT200529*, to two different bulletins. The first bulletin, *BT200529*, dated December 1, 2005, is called "Changes in the Preferred Drug List." The second bulletin was incorrectly assigned *BT200529* as well. This second bulletin, dated December 12, 2005, is called "Effective End Date of Current HoosierRx Program Structure and Start of State Pharmaceutical Assistance Program – HoosierRx - January 2006." Due to this situation, the first bulletin published December 1, 2005, titled "Changes in the Preferred Drug List," will be referred to as *BT200529**A***. Therefore, the second bulletin, published December 12, 2005, titled "Effective End Date of Current HoosierRx Program Structure and Start of State Pharmaceutical Assistance Program – HoosierRx - January 2006," will be referred to as *BT200529**B***.

- The Centers for Medicare and Medicaid Services (CMS) is consolidating the Medicare crossover process under a new Coordination of Benefits Agreement (COBA) initiative. In this initiative, CMS is contracting with one national Coordination of Benefits Contractor (COBC) to handle all crossover processing. The IHCP begins working with the COBC first quarter of 2006. The COBC will consolidate adjudication data from each of the Medicare intermediaries and send one transmittal of crossover adjudicated claims to the IHCP. Crossovers should continue to process as they do now, but because the interface is changing, providers need to monitor their crossover claims to ensure the process is working as expected.

- Please note the appropriate billing guidelines when submitting medical claims with modifier 50, *bilateral procedure*, on the claim detail. Indiana*AIM* calculates the payment for the procedure code billed with modifier 50 at 150 percent of the billed charge or the rate on file.

  If the CPT code description specifies the procedure as bilateral, modifier 50 should **not** be used on the claim detail. The units billed should be reflected as one (1) in field 24G of the claim for those CPT code descriptions

for bilateral procedures. If the CPT code description does not specify the procedure as bilateral, then modifier 50 should be used on the claim detail and the units billed should continue to be reflected as one (1). Providers submitting a claim with a bilateral procedure and multiple units should maintain supporting documentation in the member's medical record. Payment of claims will be monitored on a post-payment review basis.

- This article provides clarification of information published June 1, 2005, in IHCP provider bulletin *BT200511* about denied service lines on crossover claims. **Effective December 29, 2005**, the manner in which Medicare Part B crossover claims (Medical or Outpatient) are processed in Indiana*AIM* has been modified. When these claims are received in the 837 COB format, the Medicare denied service lines post as denied service lines by the IHCP. This eliminates the need for providers to adjust the claim.

  This change should expedite payment for Medicare-denied details. Currently the system will not allow payment of details that may have been denied by Medicare unless the provider first submits an adjustment to "reverse" the denied details. Effective with this change, providers may submit a "Medicaid-only" claim to receive payment for denied details, without first completing an adjustment.

  Providers may use the Web interChange to resubmit a claim previously received electronically from Medicare for consideration of the Medicare-paid service lines. However, the provider must delete the denied service lines from the claim. If the detail(s) is not removed from the claim and a provider submits a detail that reflects a zero amount in the coinsurance, deductible, psychiatric deductible, blood deductible, and Medicare-paid amounts, providers will receive an error message that states, "Detail is considered a Medicare-denied detail and should not be included on the claim. Please add crossover information or delete the detail."

  To receive payment, providers must resubmit the Medicare Part B (Medical or Outpatient) denied detail(s) as a Medicaid fee-for-service claim. The Medicare Remittance Notice (MRN) must be submitted as an attachment to the claim for verification that the service(s) was denied by Medicare.

- This article informs IHCP providers of updates to the type of bill (TOB) codes that may be submitted to the IHCP. **Effective December 29, 2005**, the IHCP is compliant with the UB-92 editor TOB code set. However, not all codes are covered by the IHCP. If a claim with a valid TOB is submitted via Web interChange or an 837I transaction, but the TOB is not covered by the IHCP program, the claim will be adjudicated and denied with edit *594, TOB is not covered by the IHCP*. If a claim is submitted via Web interChange with an invalid TOB, the provider will receive an error message that states, *Type of bill is not valid for this claim type*. If a claim with an invalid TOB is submitted via the 837I transaction, the claim file will be rejected with error code *272, invalid TOB.* This information will be reported to the provider or vendor on the Biller Summary Report (BSR). For a complete listing of error codes that are reported on a provider or vendor BSR and the complete listing of TOB codes, access the following links.

  Link for the listing of valid Type of Bill code set:
  http://www.indianamedicaid.com/ihcp/Forms/Type_of_Bill_Table.pdf

  Link for IHCP EDI reports & acknowledgements:
  http://www.indianamedicaid.com/ihcp/TradingPartner/CompanionGuides/EDI_Reports.pdf

- The IHCP Web site now includes Ambulatory Surgical Center (ASC) assignment codes and pricing. The ASC assignment codes classify CPT and HCPCS codes to a payment group based on an estimate of the facility costs associated with performing the procedures. Providers may access this information on the IHCP Web site at www.indianamedicaid.com under *Fee Schedule*. The ASC listing contains assignment codes, effective dates, and pricing. Additionally, assignment codes relating to specific CPT and HCPCS codes are available on the IHCP Web site at www.indianamedicaid.com under *Fee Schedule* using the procedure code or description search feature.

To All Nursing Facility Providers:

- Monthly quality assessment fee accounts receivables (A/Rs) are established during the last week of each month for **following month's** quality assessment. For example, A/Rs were set up for the November 2005 quality assessment on October 27, 2005. The A/R appeared on the remittance advice dated November 1, 2005; with the reason code 8463 tied to the A/R. If a provider's rate retroactively increased, the A/R on the remittance advice appears with a reason code of 8464 and reports on the same remittance advice as the provider's regular monthly assessment. If a provider's rate retroactively decreased, an expenditure payout appears on the provider's

remittance advice with a reason code of 8339 and reports on the same remittance advice as provider's regular monthly assessment.

To All Pharmacies and Prescribing Providers:

- Effective February 17, 2006, the following drug groups will be added to the State Maximum Allowable Cost (State MAC) for legend drugs rate list.

Drug Name	State MAC Rate
ALBUTEROL SUL 1.25 MG/3 ML SOL	0.54520
CICLOPIROX 0.77% CREAM	0.85310
CICLOPIROX 0.77% TOPICAL SUSP	1.15860
DESMOPRESSIN ACET 0.1 MG TAB	2.51460
DOXEPIN 150 MG CAPSULE	0.32770
ELIXOPHYLLIN 80 MG/15 ML ELIX	0.19300
FEXOFENADINE HCL 180 MG TABLET	2.13080
FLUCONAZOLE-NS 200 MG/100 ML	0.14480
GRISEOFULVIN 125 MG TABLET	1.23380
HALOPERIDOL 20 MG TABLET	2.33060
HYDROXYZINE PAM 100 MG CAP	0.29380
KETOROLAC 30 MG/ML VIAL	2.67290
LEVOCARNITINE 330 MG TABLET	0.94080
LITHIUM CIT 8 MEQ/5 ML SYRUP	0.03910
LITHIUM ER 300 MG TABLET	0.30070
MULTIVITAMIN VIAL	0.60110
METOPROLOL-HCTZ 100/25MG TAB	1.36430
NIFEDIPINE 20 MG CAPSULE	0.36760

Effective February 17, 2006, State MAC rates for the following drugs **decreases** as listed below.

Drug Name	State MAC Rate
AMITRIPTYLINE HCL 25 MG TAB	0.02150
AMOXICILLIN 500 MG CAPSULE	0.03850
BENZTROPINE MES 0.5 MG TAB	0.06660
GUANFACINE 1 MG TABLET	0.09060
MORPHINE SULF 30 MG TAB SA	0.70360
NIFEDIPINE ER 30 MG TABLET	0.80520
NITROFURANTOIN 100 MG CAPS	1.22570
NITROFURANTOIN-MACRO 50 MG CAPS	0.73070
ORPHENADRINE 100 MG TAB ER	0.67240
OXYCODONE/APAP 10/325 MG TAB	0.65550
POLYMYXIN B/TMP EYE DROPS	0.17580

Direct questions about the State MAC for legend drugs to the Myers and Stauffer Pharmacy Unit by telephone at (317) 816-4136 or (800) 591-1183, or by e-mail at pharmacy@mslc.com.

- The following is a correction to the State MAC rate information published December 13, 2005, in IHCP provider banner *BR200550*:

  Effective **January 27, 2006,** the following drug groups will be **added** to the State MAC for legend drugs rate list:

  Table 1 – State MAC Rate Effective January 27, 2006

Drug Name	State MAC Rate
ALBUTEROL 5 MG/ML SOLUTION	0.13935

  Direct questions about the State MAC for legend drugs to the Myers and Stauffer Pharmacy Unit by telephone at (317) 816-4136 or (800) 591-1183, or by e-mail at pharmacy@mslc.com.

- Effective January 1, 2006, the CMS is implementing the new Medicare prescription drug coverage. This coverage, also known as Medicare Part D, is a new benefit to help Medicare members pay for prescription drugs.

  The IHCP Web site now includes a section titled Medicare Prescription Drug Coverage. Providers should visit this section periodically at http://www.indianamedicaid.com/ihcp/ProviderServices/medicareD.asp for the latest information.

  For more information about the Medicare prescription drug benefit, visit the CMS Web site at http://www.cms.gov/medicarereform/.